Rule and Regulation 43
UNFAIR CLAIMS SETTLEMENT PRACTICES

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§ 1. Purpose

The purpose of this rule is to define certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices. Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103(1987), 23-76-119 (1987) and 23-94-204 (Supp. 1987) prohibit insurers, health maintenance organizations and risk retention groups doing business in the State of Arkansas from engaging in unfair claims settlement practices; and provide that, if any insurer or health maintenance organization or risk retention group performs any of the acts or practices proscribed by those sections with such frequency as to indicate a general business practice, then those acts shall constitute an unfair or deceptive act or practice in the business of insurance.

§ 2. Authority

This rule is issued pursuant to the authority vested in the Commissioner by Ark. Code Ann. §§ 23-61-108(1987), 23-66-207(1987), 23-76-125(1987), 23-94-107(Supp. 1987), 25-15-202(1987), et seq., and other applicable provisions of Arkansas law.

§ 3. Applicability and scope

This rule applies to all persons, to all insurance policies and insurance contracts and to all contracts, certificates, subscriber agreements, or other evidences of coverage issued by insurers, health maintenance organizations and risk retention groups, as applicable, except policies of Workers' Compensation and Employer's Liability. This rule is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103(1987), and 23-76-119(1987).

§ 4. Effective date

The effective date of this rule is January 1, 2001. Prior to the effective date of this rule, all provisions of Rule and Regulation 43, which existed prior to February 7, 2000, shall remain in effect.

§ 5. Definitions

The definitions of "person," "evidence of coverage," and of "insurance policy or insurance contract" contained in the Trade Practices Act, Ark. Code Ann. § 23-66-203(1987), and in Ark. Code Ann. § 23-76-102(1987), shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" or "Representative" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer, health maintenance organization, or risk retention group with respect to a claim;

(b) "Automobile insurance" includes, but is not limited to, insurance as defined under Ark. Code Ann. 23-89-301(1987);

(c) "Claimant" means an enrollee, a first party claimant, and/or a third party claimant, and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(d) "Complaint" means a written communication primarily expressing a grievance;

(e) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment or services under an insurance policy or contract, or health care plan arising out of the occurrence of the contingency, loss, injury, or illness covered by such policy, or contract, or plan;

(f) "Insurance Department Complaint" means a written communication regarding a complaint transmitted by the Arkansas Insurance Department;

(g) "Insurer" means any person, or risk retention group licensed or registered to issue or who issues any insurance policy or contract in this State;

(h) "Investigation" means all activities of an insurer directly or indirectly related to determination of liabilities or obligations under coverages afforded by a policy, contract, or health care plan;

(i) "Notification of claim" means any notification, whether in writing or by other means acceptable under the terms of an insurance policy, contract, or health care plan to an insurer or its agent by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(j) "Risk retention group" means a group as defined under Ark. Code Ann. § 23-94-102(10) (Supp. 1987);

(k) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract; and

(l) "Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

(m) “Health Carrier” means a health maintenance organization, hospital medical service corporation or a disability insurance company, that issues Health Insurance Contracts as defined in Subsection 5(s) of this rule. For purposes of this rule, unless otherwise stated, the term "Health Carrier" shall include a self-insured governmental or church plan, as well as third party administrators that administer or adjust disability benefits for a disability insurer, hospital medical service corporation, health maintenance organization, self-insured governmental plan or self-insured church plan. A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self-insured employer health benefits plan. A Health Carrier also does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State as described in Ark. Code Ann. §§23-62-102, 23-62-104, 23-62-105, 23-62-106, and 23-62-107 providing medical or hospital benefits for accidental injury or disability.

(n) “Health Claimant” means a Health Insured, a provider holding a valid assignment from the Health Insured, or a provider contracted with a Health Carrier, who is claiming a benefit under a Health Insurance Contract.

(o) "Health Claim Processing” or “to process a health claim” means to pay the claim, to deny the claim or to notify the Health Claimant in accordance with Subsection 12(b) and Subsection 13(a) of this rule that the Health Carrier needs additional information to process the Health Claim.

(p) “Health Claim Processing Date” or “Health Claim Payment Date” is the date the Health Carrier transmits or mails its claim payment, claim denial or notice of the need for additional information to the Health Claimant.

(q) "Clean Claim" means a claim for payment of health care expenses that is Submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the carrier's standard claim form with all required fields completed in accordance with the Health Carrier's published claim filing requirements. A Clean Claim shall not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, (2) for benefits under a Medicare supplement policy if the claim is not accompanied by an explanation of Medicare benefits or the Explanation of Medicare Benefits ("EOMB") has not been otherwise received by the Health Carrier, or (3) for which the Health Carrier needs additional information in order to resolve one or more of the issues listed in Subsection 13(b) of this rule.

(r) “Contracted Provider” means a provider that contracts with a Health Carrier to provide services for "Health Insureds" of such carrier.

(s) “Health Insurance Contract” means a disability insurance policy, a hospital medical service corporation contract, a health maintenance organization contract or a plan document issued or provided by a Health Carrier as defined in Subsection 5(m) of this rule. Health Insurance Contract shall not include a disability income insurance policy, a long-term care contract, a hospital indemnity contract, an accident only contract, or any other form of disability insurance policy that provides a benefit as a result of a sickness or accident that does not directly cover expenses related to health care treatment the insured receives.

(t) “Health Insured” means an individual who is a covered person under a "Health Insurance Contract."

(u) “Health Policyholder” means the person who owns the "Health Insurance Contract" and is responsible to pay premiums for the "Health Insurance Contract."

(v) “Provider” means a physician, hospital or other appropriately licensed health care provider.

§ 6. File and record documentation

The claim files of insurers, including Health Carriers, shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

§ 7. Failure to acknowledge pertinent communications

The provisions of this section shall not apply to persons that are defined as Health Carriers under Section 5(m) of this Rule.

(a) Every insurer, upon receiving notification of a claim shall, within fifteen (15) working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than in writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer. Pursuant to Ark. Code Ann. § 23-79-126(1987), insurers shall furnish forms for proof of loss within twenty (20) calendar days after a loss has been reported, or thereafter waive proof of loss requirements. Insurers shall not require a claimant to calculate depreciated value of personal property on forms for proof of loss.

(b) Every insurer upon receipt of any inquiry from the Arkansas Insurance Department respecting a claim shall within fifteen (15) working days of such inquiry furnish the Department with a reasonably adequate response to the inquiry.

(c) An appropriate reply shall be made within fifteen (15) working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to claimants so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

§ 8. Standards for prompt investigation of claims

The provisions of this section shall not apply to persons that are defined as Health Carriers under Section 5(m) of this Rule.

Every insurer shall complete investigation of a claim within forty-five (45) calendar days after notification of claim, unless such investigation cannot reasonably be completed within such time. If an investigation cannot be completed within the forty-five (45) day time period, insurers shall notify claimants that additional time is required and include with such notification the reasons therefore.

§ 9. Standards for prompt, fair and equitable settlements applicable to insurers

The provisions of this section shall not apply to persons that are defined as Health Carriers under Section 5(m) of this Rule, nor to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks.

(a)(1) Within fifteen (15) working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or

denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant in writing within fifteen (15) working days after receipt of the proofs of loss, stating the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) calendar days from the date of the initial notification and not more than every forty-five (45) calendar days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(b) Where there is a reasonable basis supported by specific information available for review by the Arkansas Insurance Department that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subsection (a)(1). The claimant shall be advised of the acceptance or denial of the claim within a reasonable time following a full investigation after receipt by the insurer of a properly executed proof of loss. The insurer shall comply with the provisions of the Arson Reporting-Immunity Statute, Ark. Code Ann. §§ 12-13-301(1987) -- 12-13-305(1987).

(c) Insurers shall not refuse to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.

(d) Insurers shall not continue or prolong negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty (30) working days and to third party claimants sixty (60) calendar days before the date on which such time limit may expire.

(e) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the applicable provision of a statute of limitations, as provided in subsection (d) of this section.

(f) Insurers shall mail or deliver claim checks or drafts to claimants within ten (10) working days after the claims are processed, all claim investigations are completed and said claim files are closed and ready for payment.

(g) No insurer or its agents and representatives shall fail to disclose fully to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or contract under which a claim is presented.

(h) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(i) No insurer shall deny a claim for a claimant's failure to exhibit the damaged property without proof of demand and of an unfounded refusal by the claimant to do so.

(j) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time and which seek to relieve the company of its obligations if such a time limit is not complied with, unless the failure to comply with such time limit prejudices the insurer's rights.

(k) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(l) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contains language which releases the insurer or its insured from total liability.

(m) No insurer shall delay payment of any claim under specific coverages under a contract in an attempt to settle all or a portion of the claims under other coverages provided by the policy.

§ 10. Standards for prompt, fair and equitable settlements applicable to private passenger automobile insurance

The provisions of this section shall not apply to persons that are defined as Health Carriers under Section 5(m) of this Rule.

(a) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one (1) of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured. All applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile must be paid at no cost to the insured other than the policy deductible. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile, including all applicable taxes, license fees and other fees actually incurred incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:

(A) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area; or (B) Use of one (1) of two (2) or more quotations obtained by the insurer from two (2) or more qualified dealers or appraisal services located within the local market area when a comparable automobile is not available in the local market area.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (a)(1) and (2) of this section, the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend or require that third party claimants make a claim under their own policies solely to avoid paying claims under such insurer's policy or contract.

(c) Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop. Insurers shall not require a claimant to have the automobile repaired at a specific repair shop as a condition of recovery.

(d) Insurers shall include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(e) When the insurer elects to repair, and, with the insured's written consent, a specific repair shop is selected, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at the estimate cost with no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(f) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one (1) or more conveniently located repair shops.

(g) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

§ 11. Claim Filing Requirements of "Health Carriers"

The provisions of this section shall only apply to person that are defined as Health Carriers under Section 5(m) of this Rule.

(a) Every Health Carrier upon receipt of any written inquiry from the Arkansas Insurance Department respecting a claim shall within fifteen (15) working days of such inquiry furnish the Department with a reasonably adequate response to the inquiry.

(b) If, after receipt of a complaint, the Commissioner determines that a Health Carrier's claim filing requirements are unreasonable or unduly burdensome, the Commissioner shall direct the Health Carrier to discontinue using such claim filing requirements.

(c) A Health Carrier shall provide a copy of its claim filing requirements to:

(1) a contracted provider at the time the Health Carrier and provider enter into their contract and within 15 days prior to a change to the claim filing requirements.

(2) a Health Care Insured or provider upon request, within 15 days;

§ 12. Processing of Clean Claims

The provisions of this section shall only apply to persons that are defined as Health Carriers under Section 5(m) of this Rule.

(a) A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

(b) A Health Carrier shall notify the Health Claimant within 30 days after receipt of the claim if the Health Carrier determines that the claim must be processed in accordance with Section 13 of this rule.

(c) A Health Carrier which fails to pay or deny a clean claim in accordance with Subsection (a) of this section or give notice in accordance with Subsection (b) of this section shall pay a penalty to the Health Claimant for the period beginning on the sixty-first day after receipt of the clean claim and ending on the clean claim payment date (the delinquent payment period), calculated as follows: the amount of the clean claim payment times 12% per annum times the number of days in the delinquent payment

period, divided by 365. Such penalty shall be paid without any action by the Health Claimant.

§ 13. Processing of Claims Requiring Additional Information

The provisions of this section shall only apply to persons that are defined as Health Carriers under Section 5(m) of this Rule.

(a) If the resolution of the claim requires the Health Carrier to obtain additional information to resolve one or more of the issues listed in subsection (b) of this section, the Health Carrier shall, within 30 days after receipt of the claim, notify the Health Claimant. The Health Carrier's notice shall give an explanation of the additional information that is required. The Health Carrier may suspend the claim until it receives the requested information, or in the case of a Medicare supplement policy, the claim may be suspended until the Health Carrier receives the EOMB.

(b) When there is a reasonable basis for doing so, a Health Carrier may request one or more of the following items to resolve the claim:

1. information in order to determine if a Health Insurance Contract limitation or exclusion is applicable to the claim;

2. medical information in order to determine the price for a medical procedure without a Current Procedural Terminology (CPT) Code or a Health Care Financing Administration Common Procedure (HCPC) Code;

3. information in order to determine if a Health Insured who received the claimed services is eligible under the terms of the Health Insurance Contract;

4. information in order to determine if the claim is covered by another Health Carrier, workers' compensation, a government supported program, or a liable third party;

5. information in order to determine the obligation of each Health Carrier or government program under coordination of benefits rules;

6. information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim; or

7. payment from the policyholder of premiums that were delinquent at the time the claimed services were rendered.

(c) A Health Carrier shall reopen and pay or deny a previously suspended claim within 30 days after the Health Carrier receives all the information it requested.

(d) A Health Carrier which fails to pay or deny a claim in accordance with Subsection C of this section, and that is not already subject to the penalty for the claim

imposed by Subsection 12(c), shall pay a penalty to the Health Claimant for the period beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period), calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such penalty shall be paid without any further action by the Health Claimant.

§ 14. Claim Processing Standards For Health Carriers

The provisions of this section shall only apply to persons that are defined as Health Carriers under Section 5.(m) of this Rule.

(a) Every Health Carrier doing business in this state shall strive to meet the following claim timeliness standards for processing clean claims and other [Section 13] claims:

Eighty-five (85%) percent of claims processed within 30 days
Ninety-eight (98%) percent of claims processed within 45 days

(b) If requested by the Commissioner, a Health Carrier shall provide a claims processing report showing the percentage of clean claims and other claims the carrier processed for residents of this state during the previous quarter and year to date. The report will classify claims as follows:

Clean Claims

Percent of claims processed within 30 days following receipt of the claim

Percent of claims processed within 45 days following receipt of the claim

Percent of claims processed after 45 days following receipt of the claim

Other [Section 13] Claims

(1) Percent of claims processed within 30 days following reopening of the claim.

(2) Percent of claims processed within 45 days following reopening of the claims.

(3) Percent of claims processed after 45 days following receipt of the claim.

(c) If a claims processing report to the Commissioner or other evidence obtained by the Commissioner shows a Health Carrier's clean claim or other [Section 13] Health Claim Processing has fallen below the following regulatory action standards:

Sixty (60%) percent of claims processed within 30 days
Eighty-five (85%) percent of claims processed within 45 days

1. the Health Carrier shall be required to submit to the Commissioner a remedial action plan setting forth how and when its Health Claim Processing shall be brought above the regulatory action standards. In addition, at the Commissioner's option, the Commissioner may conduct an on site examination of the Health Carrier's Health Claim Processing.

2. Depending upon the Health Carrier's response, the Commissioner, at his option, may require the Health Carrier to provide notice to its Health Claimants and contracted providers of delays in Health Claim Processing and the steps being taken to improve this status.

3. A Health Carrier which has failed to meet the regulatory action standards shall be required to provide the Commissioner a claim processing report on a monthly basis until the Health Carrier meets the 85% and 98% standards for both clean claim and other [Section 13] claim processing for two consecutive quarters.

4. Nothing in this rule shall limit or restrict the Commissioner from pursuing any other remedy or action against the Health Carrier under Ark. Code Ann. § 23-66-201(1987), nor act to limit any other administrative action against a Health Carrier under the Arkansas Insurance Code.

(d) A Health Carrier may be waived from the Health Claim Processing standards under this Section 9 if its Health Claim Processing system is seriously impacted by a natural disaster or if the Health Carrier obtains approval from the Commissioner for a good cause shown. A Health Carrier, in requesting the Commissioner's waiver of the Health Claim Processing standards, must specify the reason(s), give its best estimate when the Health Claim Processing standards will again be met, and commit to provide the Commissioner periodic progress reports. In the case of a natural disaster, the Health Carrier shall notify the Commissioner as soon as possible after the event, specify when the claims system will be restored and commit to submitting periodic progress reports to the Commissioner. The Commissioner shall publish a waiver granted to a Health Carrier on the Arkansas Insurance Department web site.

§ 15. Request for Investigation

The provisions of this section shall only apply to persons that are defined as Health Carriers under Section 5.(m) of this Rule.

(a) A Health Claimant may file a consumer complaint with the Commissioner relating to a Health Carrier when there is a reasonable basis for such complaint due to the failure of the Health Carrier to process claims according to this rule. However, if the Health Claimant is not the actual insured under the policy, nor the enrollee in the plan, the Health Claimant may file a consumer complaint with the Commissioner where there is a reasonable basis to believe that the Health Carrier has exhibited a practice of not paying that provider's claims according to this rule.

(b) The Commissioner shall investigate such complaint and shall make a report of his findings available to the Health Claimant who filed the complaint.

§ 16. Minimum standards for pre-certification or pre-authorization reviews as to disability coverage

The purpose of this section is to define certain minimum standards for insurers utilizing pre-certification or pre-authorization reviews to ensure that such cost-containment procedures of disability insurers and health care plans are reasonable and do not unduly delay, or interfere with or impede the authorized practice of medicine and delivery of reasonable medical care. For purposes of this rule, acts of the claims administrator in performing pre-certification reviews shall be deemed to be acts of the insurer.

From and after one hundred and eighty (180) days from the effective date of this rule, insurers utilizing such reviews shall establish reasonable procedures to:

(a) Ensure that pre-certification reviews are completed in a prompt and timely manner;

(b) Avoid excessive, repetitious and duplicative requests for information to claimants and their health care providers;

(c) Provide for reconsideration or medical reviews following disapproval or denial of pre-certification requests of insureds and claimants; and

(d) Provide for prompt peer medical review following disapproval or denial of pre-certification requests of insureds or claimants as to medically-necessary and/or life-threatening major surgical procedures.

§ 17. Severability

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision of this rule.

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MIKE PICKENS
INSURANCE COMMISSIONER
STATE OF ARKANSAS

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DATE